

Abstracts

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time may be more influential, but more research is needed to ensure appropriate consideration and valuation of leisure.

PATIENT REPORTED OUTCOMES

PRI

HEALTH RELATED QUALITY OF LIFE IN DIFFERENT STATES OF BREAST CANCER

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OBJECTIVES: The aim of this study was to describe the health related quality of life (HRQoL) in different breast cancer disease states using preference-based measures. **METHODS:** A total of 361 consecutive breast cancer patients attending the breast cancer outpatient clinic at Karolinska University hospital Solna for outpatient visits between April and May 2005 were included in the study. The EQ-5D self classifier and a direct Time Trade Off (TTO) question was used to estimate the HRQoL in different breast cancer disease states. **RESULTS:** All of the different disease states had lower HRQoL compared to the general population. Patients in their first year after a primary breast cancer had a mean EQ-5D index value of 0.696 (95% confidence interval (CI): 0.634–0.747). Patients in their first year after a recurrence had a mean EQ-5D index value of 0.779 (CI: 0.700–0.849). Patients whom had not had a primary breast cancer diagnosis or a recurrence during the previous year had a mean EQ-5D index value of 0.779 (CI: 0.745–0.811). Patients with metastatic disease reported the lowest HRQoL values, and had a mean EQ-5D index value of 0.685 (CI: 0.620–0.735). The main driver behind the reduction in HRQoL was pain and discomfort as well as anxiety and depression. TTO values were higher for all diseases states compared to the EQ-5D index values. **CONCLUSION:** This study shows that breast cancer is associated with a reduction in HRQoL. This effect is most pronounced for patients with metastatic disease. Our results also indicate that breast cancer has a permanent negative effect on HRQoL, even if the patient remains recurrence free.

PR2

ESTIMATING UTILITY VALUES FOR HEALTH STATUS USING THE SPANISH VERSION OF THE SF-36. DATA OF VALIDITY OF THE SF-6D VS EQ-5D IN SPAIN

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OBJECTIVES: A new utility index derived of the SF-36, the SF-6D, was recently developed and has generated an increasing research in different groups of patients and has also been compared with other utility measures, as it is the EQ-5D. The purpose of the present work is to validate this index in the Spanish version of SF-36 with respect to the Spanish version of the EQ-5D. **METHODS:** A total of 1843 complete measures of the SF-36 (version 2) and the EQ-5D (5 items and visual analogic scale-VAS) from 1283 patients who received a solid organ transplant (kidney, liver, heart or lung) were used. Data were collected at different moments during the first year after the surgery in the context of the Spanish Research Network on Transplantation. SF-6D values were calculated using the model proposed by its creator. EQ-5D values were calculated using Spanish VAS tariff (VAS-t) and time-trade off tariff (TTO-t). Spearman correlation coefficients were calculated between SF-6D and EQ-5D values. **RESULTS:** Mean value (SD) of SF-6D was 0.67 (0.15) (range 0.3–1.0), of EQ-5D VAS-t, 0.69 (0.24) (range –0.08–1.0) and of TTO-t, 0.70 (0.32) (range –0.7–1). Percentage of subjects

scoring the maximum was 1.1% for SF-6D, and 24.5% for the EQ-5D. SF-6D values had moderate correlation with EQ-5D VAS-t ($r = 0.734$) and EQ-5D TTO-t ($r = 0.731$) (both $p < 0.001$). **CONCLUSIONS:** The SF-6D index derived from the Spanish version of SF-36 seem to be a valid utility index to be used with the SF-36 databases from studies made in Spain. However the moderate correlation between both utility measures indicates that probably they partially measure different concepts.

PR3

LOW ADHERENCE WITH GASTROPROTECTIVE AGENTS WHEN CO-PRESCRIBED WITH NSNSAIDS ASSOCIATED WITH INCREASING RISK OF GI-RELATED HOSPITALISATION

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OBJECTIVE: Lack of adherence with gastroprotective agents (GPAs) when prescribed with non-selective (ns) NSAIDs may increase risk of hospitalisation for gastrointestinal (GI) conditions. This study assessed the effect of frequent nsNSAID use with varying levels of GPA use on GI outcomes. **METHODS:** Prescription data from a primary care database (DIN-LINK), representative of the UK population, containing records of over 800,000 patients, was used. Patients with osteoarthritis and/or rheumatoid arthritis who received nsNSAID therapy and co-prescribed GPA between September 2003 and August 2005 were identified. Adherence (proportion of days covered (%)) at monthly intervals was defined as days on gastroprotective therapy within a moving window of three consecutive months on nsNSAID. Patients were assessed according to their level of GPA use (0–19, 20–39, 40–59, 60–79, 80–99, 100%). Records of hospitalisation for GI conditions (also available in the database) at monthly intervals were analysed as a function of GPA adherence. Odds ratios of GI-related hospitalisation between cohorts of varying GPA use were calculated. Additional analysis was performed according to GI risk factors. **RESULTS:** The database identified 15,956 patients with an NSAID prescription for at least 75% of the examined period, and of these, 8890 patients with a GPA co-prescription with at least 20% use. The rate of GI-related hospitalisation for the defined period was 2.49% with full (100%) GPA use. The odds ratio for GI related hospitalisation of the sub-cohorts vs. that with 100% adherence (95% CI), in decreasing order according to adherence, was 1.57 (1.14–2.16), 1.49 (0.95–2.36), 2.85 (1.84–4.43), 3.52 (2.28–5.44), 1.47 (1.19–1.81). The odds of GI-related hospitalisation were up to 3.5 times higher for NSAID users with poorer GPA adherence. **CONCLUSION:** Analysis of observational clinical and prescription data revealed that the lower the GPA use of frequent NSAID users, the higher the rates of hospitalisation for GI conditions.

PR4

PREFERENCES OF PEOPLE WITH DIABETES FOR INHALED AND INJECTABLE INSULIN REGIMENS

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OBJECTIVE: To elicit single-index preferences from people with diabetes for treatment with inhaled insulin compared to injectable insulin. **METHODS:** Written descriptions were developed for five clinical scenarios in Type 1 and Type 2 diabetes (T1D and T2D): 1) pre-mixed insulin in T1D; 2) basal-bolus insulin in T1D; 3) pre-mixed insulin in T2D; 4) oral treatment in T2D; and 5) oral treatment plus basal insulin in T2D. In each scenario, adjustment or initiation of insulin treatment was